THE FUTURE OF AMERICAN MEDICINE

An Address by

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NOTE: This text was the basis of the Administrator's oral remarks and should be used with that understanding

Today, I want to discuss with you the future of health care in America. I especially want to talk with you about financing health care.

That's not only because this issue plays a major role in my daily life as administrator of the Health Care Financing Administration...but also because it will inevitably, if regrettably, play a major role in your daily lives as physicians.

So forgive me if I address this group of physicians sounding more like a economist than a physician. I spend a lot of time these days with economists, and lawyers as well, I regret to say.

My task in Washington to run the Medicare and Medicaid programs, a $110 Billion annual enterprise.

Our agency is usually known by its four-letter acronym, HCFA, which is often a favorite four-letter cuss word in the medical community.

HCFA is constantly vilified as a bureaucracy bent on interfering in medical decisions.

I can remember being at a gathering where, after finishing my description of Medicare's proposed agenda, a man stood up in the audience and said that all he wanted to do was "get the government out of the Medicare program."

But of course, the government IS the Medicare program. And Medicare is a dominating force in American health care, like it or not.

That's the way it is, and the best way I can help you to shape your futures as physicians is to tell it the way it is.

I wish I could say that everything is coming up roses. But it is not. It is difficult being a physician today...and it will get increasingly more difficult.

In the words of Winston Churchill, the future in large part is filled with "blood, sweat and tears."

Yet there is a bright side to all this. These challenges remind us that we are practicing a profession, not a business, and we need to take our duty very seriously.

With that in mind, I would like to discuss two very important issues.

First, I want to talk about quality in health care, with an emphasis on the government's role in measuring quality care.

In this vein, I will talk about our recent release of hospital mortality information, and tell you about our upcoming plans to measure the effectiveness of care.

Then, secondly, I would like to broaden the discussion, to consider some of the problems with the current micromanagement of health policy, as well as some suggestions for the future direction of American medicine.

I. Quality of Care

Everybody today is for quality -- "motherhood, apple pie and quality in health care." But we need to ask very seriously what quality is, how to define it, and how to measure it.

It is nonsense to pretend that all doctors and all hospitals offer care of equal quality. Of course they don't. And we should be at the forefront in discriminating among physicians and hospitals, pointing out our findings to our patients.

Mortality Information

Medicare has been actively involved in finding new methods for statistically measuring quality of care.

In December 1986 we convened a quality of care symposium which included professionals from consumer groups, hospital groups and the AMA.

These discussions lead directly to last December's release of information on mortality rates for Medicare patients at nearly 6,000 hospitals nationwide.

We pulled out all the stops in making sure this information was used in an informative way.

We held workshops to educate the media, and I held several interviews. Through it all, we were careful to point out that this information was not a perfect measure of quality of care. Rather, it was a first step.

The information is not appropriate for ranking or comparing hospitals. Rather, it is designed to provide an incentive for physicians to look carefully at the way they are practicing their profession. And to encourage patients to pose thoughtful questions.

We decided to release this information NOT because we had to, or because it was required by Congress, but because it was the right thing to do. This information is an important contribution to the existing body of knowledge about health care.

We plan to continue to improve our measurement of quality of hospital care. And we intend to go beyond that to measure quality care by other providers, including nursing homes, HMOs, and ultimately, individual physicians.

Given the current state of the art of computer technology, such measurement is well within our grasp. To some, this is very threatening. But I encourage all of you to see it as an opportunity to be leaders in this important field, rather than reluctant followers.

If you believe, as I do, in a more competitive health care system, you must also believe in providing more information, to establish a more informed public.

Effectiveness

We plan to spend much of 1988 focusing new attention on the next level of concern about quality: effectiveness.

This sort of study goes by many names, but the essence of our efforts is to find out what works in the practice of medicine.

Every year, we as a nation spend billions of dollars pushing

back the frontiers of knowledge in medical research.

Yet when it comes to some very practical matters, we are woefully uninformed.

We have a lot more to learn about the relative efficacy of various treatments, their cost-effectiveness, and the benefit of additional medical services.

We are convinced that this is a most important priority, and we are prepared to commit Medicare trust fund dollars to determining the proper role we must play in the effort.

A growing body of medical literature says that not all of the increased utilization of health care services are improving the quality of care.

Studies by Wennberg, Brook and others are producing information that seriously questions how doctors are utilizing many medical procedures...including common angiography, carotid endarterectomy, upper GI endoscopy, cardiac pacemaker implants and coronary artery bypass grafting, to name a few.

In our upcoming studies of effectiveness, we will coordinate our work with other government agencies, including the Public Health Service. We would also like to involve the AHA, the AMA, and other provider groups, together with insurers, consumers and beneficiaries.

This emphasis on effectiveness of care is a central part of Medicare's future. Indeed, the agenda we set now will shape HCFA long after I have left office. I welcome you to participate in this exciting new frontier.

II. Micromanagement

Naturally enough, we believe our recent efforts at measuring quality have great merit.

Yet I wonder if the same can be said about the massive outpouring of regulations that have come cascading out of Congress in recent years.

Perhaps some of you can remember the way in which President Reagan during his State of the Union message graphically illustrated the sheer bulk of recent Congressional budget handiwork.

One of those two massive bills, the Omnibus budget Reconciliation Act or OBRA '87, contains literally thousands of lines of fine print affecting the Medicare program.

The draft implementation plan for OBRA '87 prepared by the staff of HCFA is 45 pages of fine print detailing the

responsibilities facing the agency.

Another HCFA document, on the status of reports due to Congress, contains another 24 pages.

In the light of Congress's handiwork, let me quote from the 62nd Federalist Paper. In it, James Madison wrote:

> It will be of little avail to the people that the laws are made by men of their own choice if the laws are so voluminous that they cannot be read, or so incoherent that they cannot be understood; if they be repealed or revised before they are promulgated, or undergo such incessant changes that no man, who knows what the law is today, can guess what it will be tomorrow."

Perhaps Mr. Madison had premonitions of Medicare when he wrote that.

He, like his fellow Founding Fathers, was well schooled in classical Greek and Latin. But I doubt even he could have kept up with Congressional declensions from OBRA To COBRA to SOBRA and back to OBRA again.

A major choice we continue to face in health care is whether to centralize or decentralize decision-making authority in the system.

Centralization does have some merits. But America is diverse, and a diversity of voices would contribute more to health are policy than a handful of Washington policymakers and bureaucrats.

Let me apply this principle to the present and future of Medicare.

Prospective Payment

The Reagan Administration has made a major push for more competition (including market forces and appropriate incentives) in health care.

And much change has occurred in health care in the past few years -- it is often described as a "revolution." Of course, a major part of this revolution took place in 1983, with the passage of the hospital prospective payment system.

It has had far and away, the greatest effect on the health care system. It has given hospitals important incentives to deliver health services efficiently -- and it is a dramatic improvement over the old cost-reimbursement system for hospitals.

But PPS is a centrally administered national price payment

system, not price competition. The only "competition" among hospitals in providing better amenities to attract more patients.

One of the issues we have focused on more recently in HCFA is the continuing increase in cost per case under PPS. Despite strong incentives for holding costs down, they continue to rise.

On the one hand, this finding may lead us to conclude that we have not squeezed hospitals hard enough.

On the other hand, we may have given hospitals a terribly difficult task. It is open to question whether hospitals really can control the physician decisions that drive health care spending.

We face a major question: to what extent Medicare really can safely economize further in the hospital sector.

Reducing the over-supply of hospital beds is one alternative.

Given low occupancy rates, one of the major ways we could hold down Medicare hospital spending is to find the political will to allow some hospitals to go out of business.

However, I believe it is implausible to put great reliance

on such political will -- especially given our current experience with the rural hospital sector.

As PPS has pinched more tightly in rural America, the Congress has responded with special rural rules and higher rural payment updates. Some of the changes were well-warranted (and even advocated by HCFA as sound policy).

However, other changes -- contemplated or proposed -- fly in the face of knowledgeable observers who recognize that some rural hospitals need to change or even close.

In my view, it is the job of Medicare to assure access to quality health services. It is clearly not our job to keep every hospital open.

Adorning a national price system with local "fixes" is clearly not the answer. To be clear, Prospective payment is <u>far</u> superior to cost-reimbursement, but it has its own faults.

PPOs

Part A hospital expenditures is not our only problem. Part B physician spending is literally out of control. As a result, this January the Part B premium rose 38.5 percent.

This change is brought about by many factors, but chief among them is the burgeoning utilization of Part B services.

We know that much of the increase in utilization is good and to be applauded -- it is doctors doing good for their patients. But we also know that some of this increase is unnecessary.

Yet I believe we need to question what has been a fundamental premise of the American health care system: "More is better." More is not necessarily better.

We need seriously to examine practice patterns and to reach consensus about appropriate patterns.

Until recently the burden of proof in this debate has been on the bureaucrats who sought to have doctors provide less to save more. But the issue has grown beyond that.

As we look for ways to constrain Part B spending growth, using incentive payment systems like PPS for doctors will be difficult.

Also, since utilization growth is the major factor, we can't depend for a complete remedy on a price mechanism like the so-called relative value scale.

The best cost-control mechanism for physician services is a

competitive system that puts patients through their own choosing under the care of physicians who utilize services appropriately.

We now have a glut of providers, both of doctors and of hospitals. It is a buyers' market and the Federal government should take advantage of it.

Our near-term strategy includes price restraint and more intensive utilization review on a case-by-case basis.

We are also developing a payment reform proposal that embodies a broader set of principles involving both cost and quality: a preferred provider organization within the Medicare program.

We would select a sub-set of doctors -- the careful and appropriate practitioners of quality medicine -- and then steer a volume of patients to them using economic incentives, such as lower beneficiary copayments.

PHPO

But, having told you about the problems we have in Medicare Part A and Part B, let me say clearly: There <u>is</u> a <u>better</u> way of dealing with these problems -- the Private Health Plan Option under Medicare.

Under our uniquely American system of separation of powers with checks and balances, I believe it is much better to rely on a decentralized system and private health plans in Medicare.

Under a 1982 law change, much has been accomplished with HMOs and CMPs in Medicare.

We now have Medicare risk contracts available as a choice for more than one-half of our 31 million beneficiaries.

And about one million have so chosen. The advantages of such plans to our beneficiaries are many -- more benefits, lower copayments, less paperwork.

I am not here to sell HMOs. They must prove themselves in competition with a traditional Medicare program that is becoming increasingly more lean, mean and efficient.

We are engaged in a "market test" of the Private Health Plan Option in Medicare. It is up to us in HHS to prove whether we can operate the program in a fair and beneficial manner.

We also seek to launch a series of demonstrations of another type of capitated plan -- based on pre-formed groups of Medicare beneficiaries.

The retired enrollees in an employer or union operated health plan would participate in a Medicare Insured Group demonstration.

We recently signed an agreement with the Amalgamated Life Insurance Company to develop such a demonstration.

The essential philosophy behind the Private Option is choice...choice for consumers and choice for physicians, who are the ones best able to design local health-care plans to meet local needs.

III. The Future of Medicine

Let me close with some additional reflections on the future.

We have a real contrast between the conventional wisdom and reality in health care.

For example, the conventional view is that there have been major "cuts" in the Medicare program in recent years. In fact, Medicare has grown more rapidly than the Department of Defense Budget in the period 1981 through 1987.

Further, there is the view that the American people value health so highly that they will pay any price, bear any burden,

to have the finest in health care.

The reality is much more complex than such sloganeering.

I believe we will always devote a large share of our economy to health care.

However, what I think is growing is a demand for value in health spending. Value in the sense of paying for procedures that are effective...and value in the sense of investing dollars in ways that have the most return.

Surely there are limits to our resources. One of the uncomfortable realities, now dawning in the late 1980s, is that our aspirations have outstripped our resources. Therefore we must do a much better job of targeting our health care spending.

This will necessitate hard choices -- by people of good will. As I have said at length earlier, I believe decentralized decisions of this sort are likely to prove better than centralized ones.

As we look carefully at the American health care system, I believe that -- despite our deep-seated ambivalence about intruding on physician independence -- we cannot have unfettered physician decision-making and at the same time slow health cost growth.

There is surely room for debate about how to constrain physician decision-making, but not whether to do so.

As we analyze the system, is the glass half-empty, or half-full?

In a time of change, the medical profession should not lose sight of its mission. Medicine must maintain its fiduciary role in caring for patients.

This means doing what you believe is best for your patients, but at the same time being committed to measuring your own performance and that of your colleagues...and acting on this information.

In the long run this will be the main way the medical profession will maintain its credibility in this new age of information and accountability.

We must resist telling ourselves that the old ways were the best ways, and commit ourselves to the enterprise ahead.

In this way, today's economic reality can be an instrument for a profound and satisfying change in American medicine.

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